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BUPA DENTAL PLAN

POLICY SUMMARY

Member pay group effective from 1 December 2014

bupa.co.uk

SUMMARY OF COVER AND BENEFITS

This policy summary contains key information about Bupa Dental Plan. You should read this carefully and keep it in a safe place afterwards. Please note that it does not contain the full terms and conditions and exclusions of cover which you will find in the Bupa Dental Plan Membership Guide (Member Pay).

About your cover

The provider

Bupa Dental Plan is provided under an agreement between you and Bupa Insurance Limited (Bupa, we, us, our), a subsidiary of the British United Provident Association Limited. Other services are provided by or via other subsidiary companies.

How long your cover will last

Bupa Dental Plan is an annual contract that is renewed each year and will continue until:

- you stop paying subscriptions to it
- you cease to live in the UK

Bupa has the right to make changes to the terms and conditions of your cover on any annual anniversary date after your policy has started or end the scheme. *(See the 'How your membership works' section of the membership guide for full details).*

Where cover extends to dependants their cover may end at a different date but will always end when the main member's cover ends.

Getting in touch

The Bupa helpline is always the first number to call if you need help or support or if you have any comments or complaints. For queries about your cover we have provided a number which you will find in your membership certificate. Alternatively you can write to us at Bupa Dental, Anchorage Quay, Salford Quays, Manchester, M50 3XL or fax us on 0161 931 5883.

We want to make sure that members with special needs are not excluded in any way. We can offer a choice of braille, large print or audio for correspondence and marketing literature.

Please let us know which you would prefer.

Members with hearing or speech difficulties, who use a text phone, can contact our text phone on 0845 606 6863.

SUMMARY OF COVER

The summary of cover below sets out the eligible dental treatments which are covered.

Type of treatment	Core	Level 1	Level 2	Level 3	Level 4
Overall annual limits					
Routine dental treatment	100% reimbursement for NHS treatment. Reimbursement of private treatment up to the NHS Band limit applicable at the date of the treatment	No maximum annual limits see below benefit table for individual treatment limits			
Emergency dental treatment (includes worldwide cover)	100% reimbursement for NHS treatment. Reimbursement of private treatment up to the NHS Band limit applicable at the date of the treatment	up to a total amount of £400 each year	up to a total amount of £600 each year	up to a total amount of £600 each year	up to a total amount of £1,000 each year
Dental injury treatment	100% reimbursement for NHS treatment. Reimbursement of private treatment up to the NHS Band limit applicable at the date of the treatment	up to a total amount of £3,000 each year	up to a total amount of £5,000 each year	up to a total amount of £5,000 each year	up to a total amount of £5,000 each year
100% NHS treatment	100% reimbursement				
Oral cancer treatment	n/a	no annual benefits limit - paid in full*			
Cash benefit for hospital stay	n/a	£50 a night up to £1,000 each year			

*When we say paid in full, we mean that all of the member's eligible oral cancer treatment expenses will be covered, provided that they are treated at one of our partnership facilities by one of our partnership consultants. Please refer to the relevant membership guide for more details.

NHS annual benefit limits	Band 1	Band 2	Band 3
	100% reimbursement		

Item of dental treatment	Level 1	Level 2	Level 3	Level 4
Benefit limits				
Examinations	up to £25 up to a maximum of two each year	up to £35 up to a maximum of two each year	up to £50 up to a maximum of two each year	up to £60 up to a maximum of two each year
X-rays	up to £30 each year	up to £40 each year	up to £50 each year	up to £60 each year
Scale and polish up to a maximum of two each year	up to £40	up to £50	up to £80	up to £90
Fillings - including root canal treatment	up to £150 each year	up to £250 each year	up to £300 each year	up to £350 each year
Extractions	up to £100 each year	up to £150 each year	up to £200 each year	up to £200 each year
Crowns, Bridgework, Denture, and Surgical Implants	80% of costs up to £275 each year	80% of costs up to £450 each year	80% of costs up to £550 each year	80% of costs up to £2,000 each year
Anaesthetist	up to £30 each year	up to £50 each year	up to £60 each year	up to £80 each year
Orthodontic cover	Up to £300 each year	Up to £400 each year	Up to £500 each year	Up to £600 each year

What your policy does not cover

This section explains the dental treatment services and charges that are not covered under the scheme. This section does not contain all the limits and exclusions to your cover. For example, you are only covered for dental treatment services set out in the benefit schedules; anything not set out there is not covered. You should also note the benefit schedule sets out some limitations and restrictions for particular types of dental treatment.

(See 'Exclusions on benefits' in the 'General rules on benefits' section of the membership guide for full details).

The following are excluded:

- **cosmetic treatment**
- **orthodontic treatment** that is grade 1-3 on the IOTN scale or which is not **clinically necessary**
- **surgical implants** where they are to be used for the correction of pre-existing gaps that occurred prior to the start date of your policy
- mouth guards required for **physical contact sports**
- any **dental treatment** or services not normally provided by a **dental professional** in the **United Kingdom**
- the replacement of a **prosthetic appliance** which has been lost or stolen other than in mouth
- the replacement of a **prosthetic appliance** which could have been repaired according to generally accepted dental standards
- the replacement of a **prosthetic appliance** within five years (except dentures) of it having been fitted
- any **dental treatment** resulting from or related to any injury sustained whilst participating in **physical contact sports**
- any **dental treatment** resulting from or related to a self-inflicted injury
- any **dental treatment** required as a result of nuclear or chemical contamination, war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, terrorism, insurrection, or military or usurped power
- any **dental treatment** which in **Bupa's** reasonable opinion based on established dental and medical practice in the **United Kingdom**, is experimental or unproven, except where **dental treatment** is obtained overseas in which case the reasonable opinion will be based on established dental and medical practice in that jurisdiction.
- **Bupa** may, at its sole discretion, make payments in the event that you or any of your **eligible dependants** requires such **dental treatment**. No costs and expenses for experimental or unproven **dental treatment** will be reimbursed unless incurred with **Bupa's** prior written approval.
- any **dental treatment** received outside the **United Kingdom** which is not **emergency dental treatment**
- self administered drugs such as antibiotics and painkillers or prescription charges
- any **oral cancer treatment** received by you or any of your **eligible dependants** if the oral cancer was diagnosed:
 - a. before the person with the oral cancer began their current continuous period of membership of the scheme (or any Bupa Dental Choice scheme which included cover for those types of treatment).
 - b. during the first six months of their current continuous period of membership of the scheme.
- any **oral cancer treatment** if the person receiving the treatment has not been referred to the specialist registered medical practitioner by their GP or **dental professional**
- any **dental injury treatment** arising as a direct or indirect result of an external impact which occurred before the date of enrolment of the scheme
- any **dental injury treatment** arising as a direct or indirect result of an external impact which occurred outside the UK
- dental procedures carried out in hospital, for example wisdom teeth extractions
- dental consumables such as toothbrushes, mouthwash and dental floss.
- treatment care or repair to gums, teeth, mouth or tongue in connection with mouth jewellery
- **dental injury treatment** required as a result of injury caused by foodstuffs or foreign bodies while eating, chewing or drinking.

Changing your mind

You can change your mind within 21 days:

- of the day when your policy starts or, if later,
- the day when you receive your policy membership guide and your membership certificate

As long as you have not made any claims, we will refund all your subscriptions.

After this time, if you decide for any reason, that you do not want your Bupa Dental Plan policy after all, we will refund any subscriptions in respect of your membership which relates to a period after it ends. (See the 'How your membership works' section of the membership guide).

Making a complaint

We are committed to providing you with a first class service at all times and will make every effort to meet the high standards we have set. If you feel that we have not achieved the standard of service you would expect or if you are dissatisfied in any other way, then this is the procedure that you should follow.

If you are a member of a company or corporate scheme please call your dedicated Bupa helpline, this will be detailed on your Membership Certificate.

For any other complaint our Member Services Department is always the first number to call if you need help or support or if you have any comments or complaints. You can contact us in several ways:

By phone:

0845 609 0111**

In writing:

Customer Relations, Bupa, Salford Quays, Manchester, M50 3XL

By email:

customerrelations@bupa.com

Or via our website:

bupa.co.uk/members/member-feedback

How will we deal with your complaint and how long is this likely to take?

If we cannot resolve your complaint immediately we will write to you, within five working days, to acknowledge receipt of your complaint. We will then continue to investigate your complaint and aim to send you our full written final decision within 15 working days. If we are unable to resolve your complaint within 15 working days we will write to you to confirm that we are still investigating your complaint.

Within eight weeks of receiving your complaint we will either send you a full written final decision detailing the results of our investigation or send you a letter advising that we have been unable to complete the review of your complaint.

If you remain dissatisfied after receiving our final decision, or after eight weeks you do not wish to wait for us to complete our review, you may refer your complaint to the Financial Ombudsman Service. You can write to them at: Financial Ombudsman Service, Exchange Tower, London, E14 9SR or call them on 0800 023 4567 (free for fixed line users) or 0300 123 9 123 (free for mobile-phone users who pay a monthly charge for calls to numbers starting 01 or 02). For more information you can visit www.financial-ombudsman.org.uk

Your complaint will be dealt with confidentially and will not affect how we treat you in the future.

Whilst we are bound by the decision of the Financial Ombudsman Service, you are not.

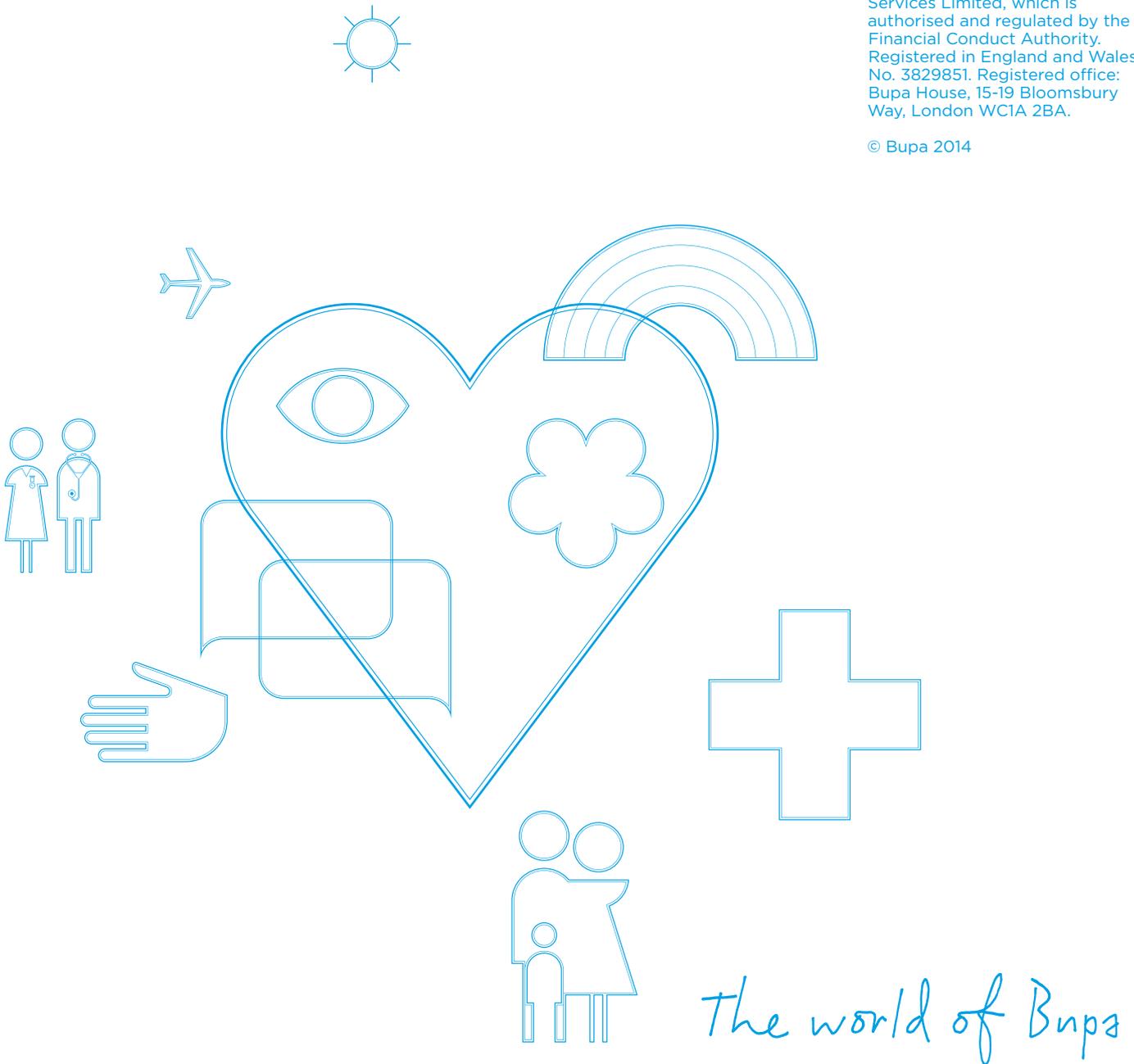
The Financial Services Compensation Scheme (FSCS)

In the unlikely event that we cannot meet our financial obligations, you may be entitled to compensation from the Financial Services Compensation Scheme. This will depend on the type of business and the circumstances of your claim. The FSCS may arrange to transfer your policy to another insurer, provide a new policy or, where appropriate, provide compensation.

Further information about compensation scheme arrangements is available from the FSCS on 0800 678 1100 or on its website www.fscs.org.uk

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